The PRESIDENT said he was much interested in the age of the patient, which was earlier than usual in these cases. Apparently the reactions in the left ear proved to be normal, with the exception of a delayed labyrinthine reflex. The only way to know whether the eighth nerve was involved or not, to appreciate how far the disease could have advanced, was its effect on the function of hearing. Cushing had been a little severe in his remarks at the expense of otologists because the latter did not diagnose the cases earlier, and yet this case shows a left-sided tumour as large as a hazel-nut without producing any symptoms.

Mr. ORMEROD (in reply) said that at the time he felt satisfied that Rinne was negative on the right side. He was surprised to find no changes in hearing on the left side, because in a case of neurofibromatosis he expected there would be a tumour on both sides. A normal response was obtained from the left horizontal canals, but it took more than a minute of cold syringing to produce, instead of thirty seconds.

Chronic Mastoiditis with Functional Paralysis of the Leg. Operation: Recovery.—N. ASHERSON, F.R.C.S.

An obedient, docile girl, aged 12, with a chronic ear discharge (left), present for years, complained of falling over to the right for about five weeks. She cannot stand upright or walk. The left ear showed active attic suppuration: some horizontal nystagmus; labyrinthine in nature; a negative fistula test; some slight past-pointing to the left. There is no nausea, no vertigo, no vomiting. The caloric and hearing tests reveal an active labyrinth on the left side.

Dr. D. W. Winnicott detected that while the patient, on attempting to stand on both feet, fell to the right, she could stand upright on the left leg alone. It is only when she attempts to stand on both feet that she falls. She can sit up without falling.

A functional condition was diagnosed.

In November, 1931, the left radical mastoid operation was performed and much disease was found, but the dura and sinus were not exposed. Consequently I refrained from exposing and exploring the middle or posterior cranial fossa.

Recovery was uneventful. The paralysis cleared up and has not recurred so far, twelve months since the time of operation. The ear is now dry.

Discussion.—The PRESIDENT said that it was a question whether the condition was functional, or whether there was a cortical disturbance on the same side as the ear lesion.

Mr. W. STIRK ADAMS asked that more details of the apparently spontaneous nystagmus should be given; the notes did not state the direction or the quality of the nystagmus. These details might throw light on unknown functions of the labyrinth. He (the speaker) considered that it had functions in the static sense which there were no means of testing at present.

Post-operative Mastoid Fistula: Closure by use of Temporal Muscle Transplant.—N. ASHERSON, F.R.C.S.

I operated on this girl for acute zygomatic mastoiditis a year ago. The operation left a deep, granulating fistula.

The edges of the fistula were elevated, and a portion of the temporal muscle was transplanted into the cavity. It was retained in position by a stitch to the lower fold, and the skin was sutured over it. Healing was by first intention.

Discussion.—The PRESIDENT said that he felt annoyed if there was a post-operative fistula in any of his cases, and he attributed that occurrence mainly to the method of using packing in the mastoid cavity subsequent to the operation. If left to other people the packing was pressed upwards, and the wound was carried to the upper recess. If packing was inserted through the lower part until the scar was well consolidated above, these sinuses would not occur. Another factor was pressure on the pinna by bandages and dressings. Years ago Mr. Stuart-Low had pointed out that it was important to avoid pressure on the pinna, as it dragged the edges of the wound apart, resulting in a fistula.